

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 801

1. PLACE OF DEATH:

County Washington
 City or town Williamsport, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 74 yrs.
 Hospital, institution, or street address where death occurred:
10 Vermont St. Williamsport
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Williamsport, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 10 Vermont St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Charles Albert Ardinger

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary C. Ardinger
 6.(c) If alive, give age 74 years
 7. Birth date of deceased (mo., day, yr.) May 15 1872
 8. AGE: Years 74 Months 11 Days 17 If less than one day _____ hrs. _____ min.
 9. Birthplace Williamsport, Maryland
 (Town, county, and state)
 10. Usual occupation Labor
 11. Industry or business Byrons Tannery
 12. Name James Ardinger
 13. Birthplace Williamsport, Maryland
 14. Maiden name Emma Netzel
 15. Birthplace Williamsport, Md.

16. Informant Mr. Frank Ardinger
 Address Williamsport, Md.
 17. Burial Date thereof May 5 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Riverview Cemetery
Williamsport, Md.
 Location
 18. Funeral director Edith V. Leaf
 Address #7 Church St. Williamsport, Md.
 19. May 5 1946 Mrs. E. L. McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 46 at 11 30 M
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April - 15 19 46 to May 2 19 46
 and that I last saw him alive on May 1 19 46
 Immediate cause of death Diabetic gangrene DURATION 2 weeks
 Due to Diabetic mellitus 8 years
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dr. E. L. McElroy M. D. or other
 Address Williamsport, Md. Date signed 5/7/46

RECEIVED
MAY 8 1944
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Pa)

Dr Earl Young

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 10 Mos.
 Hospital, institution, or street address where death occurred:
220 Summit Ave.
 How long in hospital or institution?..... none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 320 Summit Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3.(a) FULL NAME

Mrs. Sallie Pine Bahr

3.(b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... John W.6.(c) If alive, give age..... 53 years7. Birth date of deceased (mo., day, yr.)..... December 27, 1893

8. AGE: Years..... 52 Months..... 4 Days..... 7 If less than one day..... hrs. min.

9. Birthplace..... Martinsburg, Berkely Cty. W. Va.
(Town, county, and state)10. Usual occupation..... House Wife11. Industry or business..... Own Home12. Name..... George Cox13. Birthplace..... Martinsburg W. Va.14. Maiden name..... Adelia Cox15. Birthplace..... Martinsburg W. Va.16. Informant..... John W. BahrAddress..... Hagerstown, Md.17. Burial..... May 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Rest Haven CemeteryLocation..... Hagerstown, Md.18. Funeral director..... Andrew K. Coffman.Address..... Hagerstown, Maryland19. May 4 1946 Blanch Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 4. 1946 at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2-1-46 1946 to 5-4-46 1946
 and that I last saw him alive on 5/4/46 1946

Immediate cause of death..... congestive heart failure
 DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M.D. or other

Address..... Date signed..... 5/4/46

RECEIVED
MAY 7 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, institution, or street address where death occurred:

301 S. Potomac St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 322 Avon Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Lucy Baker

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Leo Baker

7. Birth date of deceased (mo., day, yr.)

November 8, 1903

8. AGE: Years Months Days If less than one day

42 6 11 hrs. min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Presser (Cranes clothing store)

11. Industry or business

12. Name

Henry C. Dofflemeyer

13. Birthplace

Virginia

14. Maiden name

Bessie Painter

15. Birthplace

Virginia

16. Informant

Mrs. Loyd Miley

Address

Baltimore, Maryland.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof May 22, 1946

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Maryland.

19. May 23 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1946 19 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1 Feb 1946 to 15 Mar 1946

and that I last saw him alive on 15 Mar 1946

Immediate cause of death

with Myocardial Failure

DURATION

unknown

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations. none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE F. F. Lusby M. D. or other

Address 2202 Potomac Date signed 21 May 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 25 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

05176

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Margaretville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs
 Hospital, institution, or street address where death occurred:
Margaretville Reparatite Home
 How long in hospital or institution? 15 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Washington
 City or town Margaretville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown Md. R.D.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

SARAH E. BAKER

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec 26, 1853
 8. AGE: Years 92 Months 4 Days 13 It less than one day _____ hrs. _____ min.

9. Birthplace Winchester Va.
 (Town, county, and state)
 10. Usual occupation House work
 11. Industry or business Retired
 12. Name Henry Martin Baker
 13. Birthplace Va.
 14. Maiden name Emilia Jane Taylor
 15. Birthplace Va.

16. Informant Scott Baker
 Address Wilmington Del.
 17. B Date thereof May 11/1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mt. Hebron
 Location Winchester Va.
 18. Funeral director A. E. Munnich
 Address Greencastle Pa.

19. May 10 19 46 Blackthorn
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 - 46 19 _____ at 7:30 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-1-42 19 _____ to 5-8-46 19 _____
 and that I last saw him alive on 5-2-46 19 _____

Immediate cause of death

Senility
 Due to Exhaustion
 Due to _____
 Other conditions _____

DURATION

10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Dr. O. D. Smith
 Address Sequent Date signed 6/9/46
 M. D. or other _____

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6151

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

Permanently

ARTESIAN LEADER

RAG-BONTENT

RECEIVED
MAY 13 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Breathedsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? from 7/22/45
 Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
 How long in hospital or institution? from 7/22/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1044 Pennsylvania Ave., Baltimore
 (If rural, give LOCATION)
 2. (a) If veteran, name war unknown

3. (a) FULL NAME

CHARLES WILTON BRIGHT

3. (b) Social Security Number

217-07-3102

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) June 2, 1920
 6. (c) If alive, give age years

8. AGE: Years 25 Months 11 Days 3 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation tailor

11. Industry or business

12. Name Charles A. Bright13. Birthplace Baltimore, Md.14. Maiden name Lillie Bell15. Birthplace Pennsylvania16. Informant Md. State Reformatory for MalesAddress Breathedsville, Md. (18)

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 18, 1946
 (month) (day) (year)

Cemetery or crematory Mt. Calvary CemeteryLocation Baltimore, Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Maryland

19. May 14, 46 (Date rec'd by registrar) 19 46 John H. Bush Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 14 19 46 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/22/45 19 45 to 5/21/46 19 46
 and that I last saw him him alive on 5-13 19 46

Immediate cause of death Pulmonary Tuberculosis

DURATION

2 yrs.Due to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Robert P. Courad, M.D. M. D. or otherAddress Hagerstown, Md. Date signed 5-15-46

RECEIVED
MAY 20 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of sex MARYLAND STATE DEPARTMENT OF HEALTH
is shown on

2411 N. Charles St., Baltimore (272)

CERTIFICATE OF DEATH

60
15178

Reg. Dist. No. 302

FILM No. 104 MAY 20 1946

1. PLACE OF DEATH: Washington

County: Hagerstown

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1011 Oak Hill Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1011 Oak Hill Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Annie B. Bryan

3.(b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

8.(b) Name of husband or wife: William E. Bryan

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 4 1865

8. AGE: Years Months Days If less than one day
81 3 6 hrs. min.

9. Birthplace: Caroline County, Md
(Town, county, and state)
Housework

10. Usual occupation

11. Industry or business

12. Name: Thomas Cahall
13. Birthplace: Caroline Co. Md

14. Maiden name: Augusta Atwell

15. Birthplace: Caroline Co. Md.

16. Informant: Mrs. John C Sunderland
Address: Hagerstown, Maryland

17. Burial Date thereof: 5-13-1946
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory: Chesterfield Cem.
Location: Centreville, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. May 11 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10-46 19 at 9:45 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased on

May 8-46 19 May 10-46 19

and that I last saw him alive on May 10-46 19

Immediate cause of death:

Cholelithiasis

Due to: (Congestion)

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [Signature] M. D. or other

Address: Hagerstown Md Date signed: 5/11/46

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MAY 14 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Cavetown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Cavetown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lucy Blessing Bushey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, divorced Widow
 6.(b) Name of husband or wife George M. Bushey
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 28, 1868
 8. AGE: Years 77 Months 6 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Washington County, Maryland
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business

12. Name Daniel Blessing
 13. Birthplace Frederick County, Maryland
 14. Maiden name Johanna Flecker
 15. Birthplace Washington County, Maryland
 16. Informant Frank E. Bushey
 Address Cavetown, Maryland

17. Burial Date thereof 5-19-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Smithsburg Cemetery
 Location Smithsburg, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. (Date read by registrar) May 17, 1946 Registrar Geo. W. Ferguson

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1946 at 9:20 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1945 to May 16, 1946
 and that I last saw him alive on May 16, 1946
 Immediate cause of death Pulmonary Edema
 Due to Paroxysms of
Liver
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE H. G. H. H. H. M. D. or other _____
 Address Smithsburg Date signed 5/17/46

RECEIVED
MAY 25 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington Co.
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
538 Guilford Ave.
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Bedford
City or town Hyndman Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. _____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Saddie B. Carpenter

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife _____
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 23, 1870

8. AGE: Years 75 Months 10 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Wellersburg Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Levi Riser

13. Birthplace Wellersburg, Pa.

14. Maiden name Bohen

15. Birthplace Wellersburg, Pa.

16. Informant Mrs. Francis Eldridge

Address Kiser, W. Va.

17. May 9/46 Burial Date thereof May 9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hyndman, Pa. Cemetery

Location Hyndman

18. Funeral director Harvey Zeigler

Address Hyndman, Pa.

19. May 7, 46 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 7 19 46, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 46, to May 7 19 46, and that I last saw her alive on May 6 19 46.

Immediate cause of death Lobar pneumonia

Due to _____

Due to _____

Other conditions Arteriosclerosis general.

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. Campbell M. D. or other

Address Hagerstown Date signed May 7/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

MAY 9 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

CERTIFICATE OF DEATH

05181

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Breathedsuit 'Rural'
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:
Breathedsuit Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Breathedsuit 'Rural'
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Breathedsuit Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Eastburn Chaney

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary V. Chaney
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 14, 1863
 8. AGE: Years 82 Months 10 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Breathedsuit Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Retired Passenger Conductor

11. Industry or business Norfolk and Western R.R. Co.

12. Name Dr. Joseph Penn Chaney

13. Birthplace Breathedsuit Wash. Co. Md.

14. Maiden name Maria Van Lear

15. Birthplace Breathedsuit Wash. Co. Md.

16. Informant Mrs. Mary V. Chaney

Address Brothens Virginia

17. Burial Date thereof May 23, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Marks Episcopal Cemetery

Location Cappons Wash. Co. Md.

18. Funeral director J. H. Bart & Sons

Address Boonsboro Md.

19. May 23, 1946 John H. Bart
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 19 46 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/13 19 46 to 5/21 19 46

and that I last saw him alive on 5/17 19 46

Immediate cause of death Chronic Endocarditis DURATION ?

"Nephritis ?

Due to Influenza & Intestinal

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Victor D. Miller DR. VICTOR D. MILLER,
 _____ WASHINGTON ST.
 _____ M. D. or other
 _____ HAGERSTOWN MD.
 Address Hagerstown Md Date signed 5/14/46

RECEIVED

MAY 25 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

Dr. Campbell

15182

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 Months
 Hospital, institution, or street address where death occurred:
59 East Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 59 East Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3.(a) FULL NAME

Mrs. Annie Rebecca Darr

3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow6.(b) Name of husband or wife Philip G.7. Birth date of deceased (mo., day, yr.) June 17 18608. AGE: Years Months Days If less than one day
85 10 28 hrs. min.9. Birthplace Pearl Fred. Co. Md.
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name William Tobery13. Birthplace Pearl Md.14. Maiden name Esther Peasley15. Birthplace Pearl Md.16. Informant Mrs. William C. MainAddress Hagerstown Md.17. Burial Date thereof 5/18/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. Carmel CemeteryLocation Frederick Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 16 19 46 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1946 19 46 15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 46 to 19 46and that I last saw her alive on May 10 19 46Immediate cause of death Congestion Heart Failure DURATION 6 Mos.Due to Arterio-sclerosisDue to SenilityOther conditions Chronic Valvular Heart Disease } 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Campbell M. D. or otherAddress Hagerstown Md. Date signed May 16/46

RECEIVED
MAY 18 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

CERTIFICATE OF DEATH

Reg. Dist. No. 15183305

1. PLACE OF DEATH:

County Washington
City or town Mill Point Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Bonsboro md. R. 1
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Mill Point Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bonsboro md R. 1
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Viola Elizabeth Dubel

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Trenton J. Dubel
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) October - 3 - 1885
8. AGE: Years 60 Months 7 Days 28 If less than one day..... hrs. min.

9. Birthplace Benevola Wash. Co. md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Charles Baker

13. Birthplace Benevola Wash. Co. md.

14. Maiden name Drucie Ann Wisinger

15. Birthplace Benevola Wash. Co. md.

16. Informant Trenton J. Dubel

Address Bonsboro md. R. 1

17. Burial Date thereof June 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Benevola Cemetery

Location Benevola Wash. Co. md.

18. Funeral director Wm. J. Bast & Sons

Address Bonsboro md.

19. June 3 19 46 John H. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 19 46 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 46 to May 31 19 46

and that I last saw her alive on May 25 19 46

Immediate cause of death..... DURATION

Cerebral Hemorrhage 1 year

Due to.....

Due to not known

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Dr. J. H. Wisinger M. D. or other

Address Wellington md. Date signed 6/1/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Dr. J. H. Wisinger

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1518302

1. PLACE OF DEATH: Washington
County.....
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
909 Oak Hill Ave.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland..... County..... Washington
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 909 Oak Hill Ave
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME Homer W. Eakle

3.(b) Social Security Number none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
8.(b) Name of husband or wife Genevieve Eakle
59 years

7. Birth date of deceased (mo., day, yr.) March 22, 1886

8. AGE: Years 60 Months 1 Days 15 If less than one day hrs. min.

9. Birthplace Fairplay, Washington Co. Md
(Town, county, and state)

10. Usual occupation Pharmacist

11. Industry or business

12. Name Willis Eakle

13. Birthplace Fairplay, Md

14. Maiden name Ida Warrenfeltz

15. Birthplace Fairplay, Md

16. Informant Genevieve Eakle

Address Hagerstown, Md

Burial May 10 1946

17. (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown Md

18. Funeral director C. M. Suter & Sons

Address Hagerstown Md

19. May 10 1946 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1946 at 10/20 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... for 19... and that I last saw him alive on 19... Immediate cause of death coronary occlusion DURATION 3 days

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations No Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Data of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells M. D. WASH. CO., MD.

Address Hagerstown, Md Date signed 5/15/46

MARGIN RESERVED FOR BINDING

VS A15 9-43-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

05185

91

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Kedysville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war. _____

3. (a) FULL NAME

Baby Boy Fisher

3. (b) Social Security Number

4. Sex male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 19 1946 8:05 P.M.8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. 40 min.9. Birthplace _____
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Leotis Boney Fisher13. Birthplace Kedysville, Md.14. Maiden name Mrs. Elizabeth Poffenberger15. Birthplace Kedysville, Md.16. Informant Mrs. Leotis B. FisherAddress Kedysville, Md.17. (Burial, cremation, or removal. Which?) _____ Date thereof _____
(month) (day) (year)

Cemetery or crematory _____

Location _____

18. Funeral director _____

Address _____

19. May 31, 1946 Chas. Roovers
(Date rec'd by registrar.) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19/46 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ on _____ 19 _____

Immediate cause of death Premature4 1/2 mo gestation

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter H. Shealy M.D.Address Sharpsburg, Md. M.D. or other _____Date signed 5/19/46

RECEIVED

JUN 2 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5186

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 408 West Washington Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3.(a) FULL NAME

Lutie I. Full

3.(b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife William H. Full
 6.(c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) March 27, 1873
 8. AGE: Years 73 Months 1 Days 27 If less than one day... hrs. ... min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER 12. Name Christian Fridinger

13. Birthplace Hagerstown, Maryland

MOTHER 14. Maiden name Eliza Ernle

15. Birthplace Hagerstown, Maryland

16. Informant Mrs. Theodore Fahrney

Address Hagerstown, Maryland

17. Burial Date thereof 5-27-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. May 25 19 46 Health Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 May 19 46 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 May 19 46 to 24 May 19 46
 and that I last saw him alive on 23 19 46

Immediate cause of death Intestinal obstruction DURATION 24 hours

Due to Cause of sigmoid

Due to

Other conditions Hypertension ?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. D. Layman, M.D.

Address 100 Prosser and Ant. Bldg. M. D. or other

Date signed 24 May 46

RECEIVED
MAY 28 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

05187 316
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Main St.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Edward E. Gouff

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Rose Gouff
B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) December - 25 - 1867

8. AGE: Years 78 Months 4 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Retired Railroader

11. Industry or business

12. Name Remiel Gouff

13. Birthplace Locust Grove, Md.

14. Maiden name Rachel Ann Snider

15. Birthplace Locust Grove, Md.

16. Informant Mrs. Grace M. Abell

Address Keedysville Md.

17. Burial Date thereof May 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Danvers Cemetery

Location Keedysville Md.

18. Funeral director Wm E. Bart & Sons

Address Brownstown Md.

19. May 5 1946 Registering
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 6 - 1946 at 12 - noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____

and that I last saw h. _____ alive on _____ 19____

Immediate cause of death _____

DURATION

acute coronary occlusion

Duo to _____

Duo to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

_____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide No Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

DEPUTY MEDICAL EXAM. S. Robert Wells WASH. CO., MD.

23. SIGNATURE _____ M. D. _____

Address Keedysville Md. Date signed 5/7/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05188

Reg. Dist. No.

307

1. PLACE OF DEATH:

County Washington
 City or town Sandy Hook
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 68 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Sandy Hook
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Otho Harrison

3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Eliza Jane Potts</u>		
8. (c) If alive, give age <u>68</u> years		
7. Birth date of deceased (mo., day, yr.) <u>December 8, 1877</u>		
8. AGE: Years <u>68</u>	Months <u>5</u>	Days <u>9</u> hrs. min.

9. Birthplace Sandy Hook, Washington Co., Md.
 (Town, county, and state)

10. Usual occupation Storekeeper

11. Industry or business Own Grocery Store

12. Name Samuel Harrison

13. Birthplace Maryland.

14. Maiden name Kathryn Long

15. Birthplace Virginia

16. Informant Mrs. Eliza Harrison

Address Knoxville, Md. R.D., Box 140.

17. Burial Date thereof May 19, 1946

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Virts Cemetery

Location Sandy Hook, Maryland

18. Funeral director J. H. Backus.

Address Bolivar, West Va.

19. May 18 46 Connelina H. Castle

(Date rec'd by registrar) (month) (day) (year) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 19 46 at 1201 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 19 46 to May 17 19 46

and that I last saw him alive on May 16 19 46

Immediate cause of death Cerebral thrombosis

Due to My previous Cardiac Nephritic disease

Due to Arteriosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. Backus M. D. or other

Address Jefferson Md. Date signed 5/18/46

RECEIVED
MAY 21 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

Reg. Dist. No. 365

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Washington
 City or town Breathedsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Years
 Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
 How long in hospital or institution? 3 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 713 Pierce St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3.(a) FULL NAME

Norman Hawkins

3.(b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife -
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) November 5 1908
 8. AGE: Years 37 Months 6 Days 12 It less than one day - hrs. - min.

9. Birthplace Baltimore Maryland
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business ---

12. Name Matt Hawkins
 13. Birthplace Baltimore Md.
 14. Maiden name Lena Hawkins
 15. Birthplace Baltimore Md.

16. Informant Md. State Ref. Records
 Address Breathedsville Md.

17. Burial Burial Date thereof 5/21/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Reformatory cemetery
 Location Breathedsville Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. May 21 19 46 John H. East
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 17 1946 19 46 at 10 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 19 45 to May 17 19 46and that I last saw him alive on May 17 19 46Immediate cause of death Pulmonary tuberculosis DURATION 3 yrs.Due to -Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Robert P. Conrad, M.D. M. D. or otherAddress Hagerstown Md. Date signed 5-18-46

RECEIVED

MAY 25 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-2

CERTIFICATE OF DEATH

05190

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

45 years

Hospital, institution, or street address where death occurred:

316 West Side Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 316 West Side Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jermiah Shupp Hoch

3. (b) Social Security Number

None

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married	
6. (b) Name of husband or wife <u>Anna E. Hoch</u>			
6. (c) If alive, give age <u>68</u> years			
7. Birth date of deceased (mo., day, yr.) <u>May 8, 1875</u>			
8. AGE: Years <u>71</u>	Months <u>0</u>	Days <u>7</u>	If less than one day hrs. min.

9. Birthplace Strasburg, Pa.
 (Town, county, and state)

10. Usual occupation Retired Grocer

11. Industry or business

FATHER
 12. Name Peter Hoch
 13. Birthplace Strasburg, Pa.
 14. Maiden name Not Known
 15. Birthplace LC LC

16. Informant Kenneth Hoch
 Address Hagerstown, Maryland

17. Burial Date thereof 5-17-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Spring Hill Cemetery
Shippensburg, Pa.
 Location

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. May 17 19 46
 (Date rec'd by registrar) Registrar Shaff/Bowers

MEDICAL CERTIFICATION E.D.S.T.

20. DATE OF DEATH May 15, 1946 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Fractured skull
Hemorrhage & shock

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/14/46Where did injury occur? Hagerstown, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury Fell down stairs Injured at work? No

8. Robert Wells
 WASH. CO., MD.

23. SIGNATURE

Hagerstown, Md. Date signed 5/15/46

RECEIVED

MAY 20 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BFA)

65191

FILM No. I O 4 MAY 24 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
322 North Potomac Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 322 North Potomac Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

William J. Hogan

3.(b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Widower</u>	
6.(b) Name of husband or wife <u>Mary A. Hogan</u>			
7. Birth date of deceased (mo., day, yr.) <u>August 17, 1857</u>			
8. AGE: Years Months Days If less than one day			
<u>88</u>	<u>-89-</u>	<u>8</u>	<u>25</u>
hrs. min.			

6.(c) If alive, give age years

9. Birthplace Tipperary, Ireland
(Town, county, and state)
10. Usual occupation Retired Gardener

11. Industry or business

FATHER	12. Name <u>Martin Hogan</u>
	13. Birthplace <u>Ireland</u>
MOTHER	14. Maiden name <u>Unknown</u>
	15. Birthplace <u>Ireland</u>

16. Informant Paul Hogan
Address Hagerstown, Maryland

17. Burial Date thereof 5-15-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Hagerstown, Maryland
Location

18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19. May 14 19 46 Phos H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 46 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 46 to May 12 19 46
and that I last saw him alive on May 11 19 46

Immediate cause of death Severe & Extensive Heart Disease & Aneurysm
Due to Atherosclerosis, hypertension

Other conditions Arteriosclerosis, Chronic nephritis
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

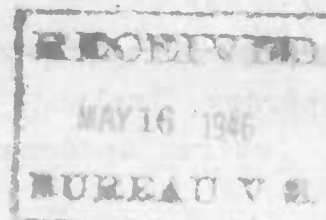
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Phos H Bowers MD
Address 1594 Washington St M. D. or other MD
Date signed 5/13/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 127

CERTIFICATE OF DEATH

Reg. Dist. No. 0519301

1. PLACE OF DEATH:

County Washington County
 City or town Downsville Md. RFD
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr - 2mo - 21 days
 Hospital, institution, or street address where death occurred:
Downsville Md. RFD
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Downsville Maryland RFD
(If outside city or town limits, write RURAL and give nearest town)
 Street No. Downsville Md. RFD
(If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Dolly Mae Householder

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Baby

6. (b) Name of husband or wife Baby

7. Birth date of deceased (mo., day, yr.) Feb. 26 1945 8. (c) If alive, give age _____ years

8. AGE: Years 1 Months 2 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Downsville Md. RFD
(Town, county, and state)

10. Usual occupation Baby

11. Industry or business Baby

MOTHER FATHER 12. Name Mr. Lenoard Householder

13. Birthplace Fairview Md.

14. Maiden name Sarah Hose

15. Birthplace Williamsport, Md.

16. Informant Mr. Lenoard Householder
 Address Downsville Md. RFD

17. Burial Date thereof May 21 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenlawn Cemetery

Location Williamsport, Maryland

18. Funeral director Edith V. Leaf

Address #7 Church St. Williamsport, Md.

19. May 21 46 Mrs E Lee McElroy
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/46 19. 11/7

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/18/46 19. to 5/18/46 19.

and that I last saw h. alive on 5/18/46 19.

Immediate cause of death Let alogia
of Fallot's from Birth

Due to Bacterial pneumonia, suppurative

Duration: two weeks

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

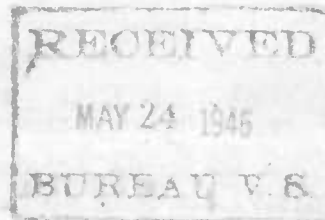
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. P. Young M. D. or other

Address Williamsport Md Date signed 5/18/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-02

CERTIFICATE OF DEATH

★ 15193302
Reg. Dist. No.

1. PLACE OF DEATH: Washington
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Washington Co Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Penna County..... Franklin
City or town..... Greencastle
(If outside city or town limits, write RURAL and give nearest town)
Street No..... RD # 1
(If rural, give LOCATION)
2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

ETHEL MARGARET HUMMER

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married
8.(b) Name of husband or wife Luther Hummer
6.(c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) Nov. 17, 1900
8. AGE: Years 45 Months 5 Days 8 If less than one day
..... hrs. min.

9. Birthplace..... Penna
(Town, county, and state)
10. Usual occupation..... House wife
11. Industry or business..... Home
FATHER 12. Name..... John Mackey
13. Birthplace..... Penna
MOTHER 14. Maiden name..... Jennie Killinger
15. Birthplace..... Penna

16. Informant..... Luther Hummer
Address..... Greencastle RD # 1
17. Burial (Burial, cremation, or removal, Which?) Date thereof..... May 29/46
(month) (day) (year)
Cemetery or crematory..... Cedar Hill
Location..... near Greencastle

18. Funeral director..... R. E. Munnish
Address..... Greencastle Pa
19. May 27 (Date rec'd by registrar) 19 46 Registrar W. H. Powers

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 25 19 46 at 10:15 P.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5/1 19 39 to 5/25 19 46
and that I last saw h. ex. alive on 5/25 19 46
Immediate cause of death..... Essential
hypertension - benign nephro-
sclerosis, & cerebral hemorrhage
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE..... W. H. Powers M. D. Greencastle Pa
Address..... Greencastle Pa Date signed 5/26/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD INVESTIGATION

FILE

Permanence

MAY 21 1946

RECEIVED
MAY 29 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05194

Reg. Dist. No. 316

1. PLACE OF DEATH:

County WashingtonCity or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 54 years.

Hospital, institution, or street address where death occurred:

Main St.
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)Street No. Main St.
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Fannie Helen Huntzberry

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single

7. Birth date of

deceased (mo., day, yr.) December - 19 - 1860

6. (c) If alive, give age

years

8. AGE:

Years 85 Months 5 Days 5 hrs. min.9. Birthplace near Boonsboro Wash. Co. Md.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Billy Huntzberry13. Birthplace near Boonsboro Wash. Co. Md.14. Maiden name Amanda Nicodemus15. Birthplace near Keedysville Wash. Co. Md.16. Informant Miss Kate HuntzberryAddress 862 Mulberry Ave Hagerstown Md.17. Burial Date thereof May 27, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Boonsboro CemeteryLocation Boonsboro Md.18. Funeral director Wm. E. Bast & SonsAddress Boonsboro Md.19. May 27, 1946 R. H. Gosting
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1946 at 10.30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1946 to May 27 1946
and that I last saw him alive on May 24 1946

Immediate cause of death

Chronic Myocarditis

DURATION

1 yr.Due to Essential Hypertension10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Bast M. D. or otherAddress Boonsboro Date signed 5/25/46

RECEIVED
MAY 28 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 150

CERTIFICATE OF DEATH

05214

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland County Washington
State.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 437 N. Jonathan Street
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME Lilly Mae Johnson

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Charles H. Johnson
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) December 24, 1884
8. AGE: Years 61 Months 5 Days 17 It less than one day..... hrs. min.

9. Birthplace Nighttown, W. Va.
(Town, county, and state)
10. Usual occupation Domestic

11. Industry or business
12. Name John Burman
13. Birthplace W. Va.
14. Maiden name Lilly Holly
15. Birthplace W. Va.

16. Informant Bruce Johnson
Address 437 N. Jonathan Street
17. Burial Date thereof 5/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Riverview
Location Williamsport, Md.

18. Funeral director William H. Downey
Address 291 Andrew St. Hagerstown
19. May 14 19 46 Registrar Charles H. Downey
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1946 19..... at..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/27/44 19..... to May 11, 1946 19.....
and that I last saw him/her alive on May 11, 1946 19.....
Immediate cause of death.....
Tuberculosis, pulmonary (advanced)

DURATION
18 mos.
Due to.....
xxx OTHER CONDITIONS
Diabetes mellitus 15 yrs.
Other conditions Hypertensive vascular disease Indef
Cerebral hemorrhage 3 days
(Include pregnancy within 3 months of death)

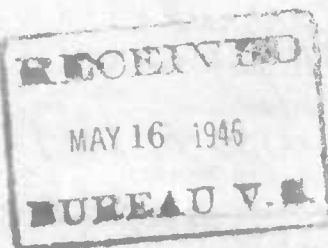
Major findings of operations..... Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?
23. SIGNATURE..... M. D. or other
Address 148 W. Washington St. Date signed 5/13/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Months
 Hospital, institution, or street address where death occurred:
1090 Virginia Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 342 So. Cannon Ave
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Mrs. Esther Elizabeth Keller

3.(b) Social Security Number

215-12-8177

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Robert E.
 6.(c) If alive, give age 35 years
 7. Birth date of deceased (mo., day, yr.) December 28 1913
 8. AGE: Years 32 Months 5 Days 3 If less than one day hrs. min.
 9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Clerk
 11. Industry or business Geigers Pharmacy
 12. Name J. Guy Weagley
 13. Birthplace Cavetown Md.
 14. Maiden name Esther E. Krouse
 15. Birthplace Cavetown Md.

16. Informant J. Guy weagley
 Address Hagerstown Md.
 17. Burial Date thereof 6/2/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. June 1 46 Blanch Bowers
 (To be rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1946 19..... al 3.30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1946 to 5/31 19 46
 and that I last saw him alive on 5/30-1946 19.....

Immediate cause of death.....

acute dilatation heart
chronic myocarditis
chronic subcarditis
arterio-sclerosis

DURATION

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Victor Miller M. D. or otherAddress..... Date signed 5/31 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1946

BUREAU V.L.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARITAL STATUS (6a,6b): certified copy of marriage certificate from Montg. Circuit ct 72
 doctor's statement also; MARYLAND STATE DEPARTMENT OF HEALTH
 filmed 3-3-47 G109.-L

2411 N. Charles St., Baltimore (B-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Capitol Hill and give nearest town

How long in above place of death

Hospital, institution, or street address where death occurred:

Wash Co Hospital

How long in hospital or institution?

4 days

3. (a) FULL NAME

18 year old Leroy Randall

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

MARRIED

6. (b) Name of husband or wife

LOLA ELIZABETH BLICKENSTAFF

7. Birth date of deceased (mo., day, year)

1928. 7. 19 day

6. (c) If alive, give age years

19 years

8. AGE:

Years

34

Months

10

Days

28

If less than one day

hrs.

min.

9. Birthplace

Smithsburg Md

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

L. M. Randall

12. Name

near Smithsburg, Md

13. Birthplace

May. Spuch

14. Maiden name

Antine. Pava.

15. Birthplace

L. M. Randall

16. Informant

Smithsburg Md R. F. D.

Address

Smithsburg Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

5-19-1946

Cemetery or place of interment

Smithsburg Md

Location

Smithsburg Md

18. Funeral director

Rev. G. Hoover

Address

Smithsburg Md

19. (Date rec'd by registrar)

May 17 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Wash

City or town

Capitol Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

none

(If rural, give LOCATION)

2. (a) If veteran, name war

World War-11

3. (b) Social Security Number

213-18-8178

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 17-46

19

at

3:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1-46

19

and that I last saw

May 16-46

19

Immediate cause of death

Chor. plom. m. Nephritis

Due to

E. m. m. m.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. E. W. Smith

M. D. or other

Address

Smithsburg Md

Date signed

5/17/46

RECEIVED

MAY 20 1946

BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8302

CERTIFICATE OF DEATH

15197

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington Co.
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 20 years
 Hospital, institution, or street address where death occurred:
Washington County Home
 How long in hospital or institution?..... 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Wash.
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Alice Keys

3.(b) Social Security Number

-

4. Sex..... female 5. Color or race..... black 6.(a) Single, married, widowed, or divorced..... single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... January 18, 1856 6.(c) If alive, give age..... years

8. AGE: Years..... 90 Months..... 4 Days..... 11 If less than one day..... hrs. min.

9. Birthplace..... Washington Co., Md.
 (Town, county, and state)

10. Usual occupation..... none

11. Industry or business.....

FATHER 12. Name..... George Keys
 13. Birthplace..... Unknown

MOTHER 14. Maiden name..... Caroline Curtis
 15. Birthplace..... Unknown

16. Informant..... Fred Long
 Address..... Hagerstown, Md.

17. Burial is (Burial, cremation, or removal. Which?) Date thereof..... May 30, 1946
 (month) (day) (year)

Cemetery or crematory..... Washington County Home
Hagerstown, Md.
 Location.....

18. Funeral director..... Scott F. Minnich & Son
 Address..... Hagerstown, Md.

19. May 28 46 (Date rec'd by registrar) Charles H. Powers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 29, 19 46, at 5:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1 19 46, to May 29 19 46
 and that I last saw h. her alive on May 22 19 46

Immediate cause of death.....

DURATION

Due to..... Arterioplegia right - 2 wksDue to..... Cerebral Hemorrhage - 2 wks

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Ernest H. Roberts

M. D. or other

Address..... Hagerstown Md. Date signed..... 5/29/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7915

REC
JUN 1 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05198

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington County
 City or town Hagerstown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Cavetown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cavetown, Maryland
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War #1

3. (a) FULL NAME

William B. Kimble

3. (b) Social Security Number

219-20-1625

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Eva Bachtell Kimble</u>			
6. (c) If alive, give age <u>44</u> years			
7. Birth date of deceased (mo., day, yr.) <u>June 15 1890</u>			
8. AGE: Years <u>55</u>	Months <u>11</u>	Days <u>14</u>	If less than one dayhrs.min.
8. Birthplace <u>Williamsport, Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Painter</u>			
11. Industry or business <u>Painter</u>			
12. Name <u>Charles Kimble</u>			
13. Birthplace <u>Williamsport, Maryland</u>			
14. Maiden name <u>Annie Kreps</u>			
15. Birthplace <u>Williamsport, Maryland</u>			

16. Informant Eva Bachtell Kimble (wife.)
 Address Cavetown Maryland

17. Burial Date thereof May 28 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Riverview Cemetery
 Location Williamsport, Maryland

18. Funeral director Edith V. Leaf
 Address #7 Church St. Williamsport, Md.

19. May 27 1946 Charles Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1946 at 3 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/21/46 to 5/25 1946 and that I last saw him alive on 5/24/46 19.....

Immediate cause of death Carcinoma of stomach DURATION 1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations Not done Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE John H. Hornbaker M.D.
 Address 154 W. Washington St. Hagerstown, Md. Date signed 5/27/46

RECEIVED
MAY 29 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Washington Co. Hospital
Stay in hospital or inst. (yrs., or mos., or days) 5 Days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Frederick
City or town Wolfsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(e) IF VETERAN, NAME WAR

3. (a) FULL NAME

Amy R. Kline

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Emma L. Kline

6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1889

8. AGE: Years Months Days If less than one day
56 4 26 hrs. min.

9. Birthplace Wolfsville, Frederick Co., Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Michael Kline

13. Birthplace Wolfsville, Md.

14. Maiden name Mary Marpan

15. Birthplace Wolfsville, Md.

16. Informant Mary Kline

Address Wolfsville, Md.

17. Burial Date thereof 5-19-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory U.B. Cemetery

Location Wolfsville, Md.

18. Funeral director Bladhill Co.

Address Middleton, Md.

19. May 16, 1946 Frank Powers
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 16 19 46, at 9:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 12 19 46, to MAY 16 19 46, and that I last saw him alive on MAY 16 19 46

Immediate cause of death Obstruction of Ileum, Acute DURATION 1 day

Due to Appendicitis, Acute with Perforation + Peritonitis 5 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Ruptured Appendix
Of operations + Peritonitis
Of autopsy Obstruction of Ileum

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Richard V. Hauser M. D. or other

Address Hagerstown, Md. Date signed MAY 16, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

MAY 22 1946

BUREAU OF

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore (Bd)

05200

Reg. Dist. No. 302

FILM No. I O 4 MAY 29 1946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred:
309 S. Cannon Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 309 S. Cannon Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mert A. Lease
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
B.(b) Name of husband or wife Emer W Lease
7. Birth date of deceased (mo., day, yr.) July 18, 1890
6.(c) If alive, give age 57 years
8. AGE: Years 56 Months 55 Days 10 If less than one day 4 hrs. min.

9. Birthplace Near Clumberland All. Md.
(Town, county, and state)
Railroad Fireman
10. Usual occupation
11. Industry or business W.M. Railroad
FATHER 12. Name Frederick Lease
13. Birthplace Near Clumberland Md.
MOTHER 14. Maiden name Maggie Connor
15. Birthplace Near Clumberland Md.

16. Informant Mr. Edward Lease
Address Hagerstown Md.
17. Burial May 24, 1946
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Rose Hill Cemetery
Cemetery or crematory
Hagerstown Md.
Location
Scott F. Minnich & Son
18. Funeral director
Address Hagerstown Md.

19. May 24 19 46 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 22 May 19 46 at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Feb 19 46 to 22 May 19 46
and that I last saw him alive on 22 May 19 46

Immediate cause of death
Arterio Sclerotic + Hypertensive
Cardio Vascular Disease
DURATION unknown
Due to
Due to
Other conditions none
(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE F F Lusk M. D. or other
Address 2301 P. Ave Hagerstown Md Date signed 22 May 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on this certificate. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 25 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Beal

05201

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Years

Hospital, institution, or street address where death occurred:

Orchard RoadHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Orchard Road

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Sarah A. Lehman

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

William B.6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

December 7 1862

8. AGE:

Years

Months

Days

If less than one day

8357

hrs.

min.

9. Birthplace

Chambersburg Franklin Co. Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name

John Houghtman

13. Birthplace

Germany

MOTHER

14. Maiden name

Catheriane Lantz

15. Birthplace

Chambersburg Pa.

16. Informant

Mrs. John R. Fisher

Address

Hagerstown Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

5/16/46

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

19.

4/6

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1946 19 46 at 4 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6, 1946 to May 14, 1946and that I last saw her alive on May 13, 1946

Immediate cause of death

Chronic Cardiovascular- Renal Disease.

DURATION

?

Due to

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations No operations

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Hagerstown, Maryland

Date signed

5-15-46

1007 1007 1007 1007 1007 1007 1007 1007 1007 1007

WATERMAN LIGHTER

500 CONTENT

RECEIVED
MAY 18 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 05202 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 years
 Hospital, institution, or street address where death occurred:
316 Linganore Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 316 Linganore Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

James Norman Leshner

3. (b) Social Security Number

214 09- 3435

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Edith Leshner
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 4, 1884
 8. AGE: Years 61 Months 5 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Millstone, Maryland
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business

12. Name Edward Leshner
 13. Birthplace Millstone, Maryland
 14. Maiden name Anna Stump
 15. Birthplace Millstone, Maryland

16. Informant Jesse Leshner
 Address Hagerstown, Maryland

17. Burial Date thereof 5 27 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven
 Location Hagerstown Md

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. May 25 1946 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

E. D. S T

20. DATE OF DEATH May 24, 1946 19____ at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw h. _____ alive on _____ 19____

Immediate cause of death _____ DURATION
Acute coronary occlusion 2 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

DEPUTY MEDICAL EXAMINER

23. SIGNATURE H. Robert Hill WASH. CO., MD.

M. D. or other

Address Hagerstown, Md. Date signed 5/24/46

RECEIVED
MAY 28 1946
BUREAU T. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of date of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. I O 4 MAY 13 1946

Reg. Dist. No.

05203

304

1. PLACE OF DEATH:

County.....Washington

City or town.....Hancock
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....28 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Washington

City or town.....Hancock
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Grace Pearl Little

3.(b) Social Security Number

NONE

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married

6.(b) Name of husband or wife.....Benjamin P. Little

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....December 2 1893

8. AGE: Years.....52 Months.....5 Days.....1 If less than one day..... hrs. min.

9. Birthplace.....Garrett Co., Md.
(Town, county, and state)

10. Usual occupation.....Home Duties

11. Industry or business

12. Name.....Carl Coffman

13. Birthplace.....Keyser W Va.

14. Maiden name.....Elnora Smith

15. Birthplace.....Morgan Co., W Va.

16. Informant.....Benjamin P. Little
Address.....Hancock, Md.

17. Burial Date thereof.....May 7 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Catholic

Location.....Hancock, Md.

18. Funeral director.....Snyder - Rowland Funeral Home

Address.....Hancock, Md.

19. 5/6/46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 3, 1946 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/3/46 at 6:35 pm to 5/3/46 at 6:45 pm and that I last saw her alive on 5/3/46 19.....

Immediate cause of death.....

Acute Congestive Heart

DURATION

1/2 hr

Due to.....Unknown

Due to.....Unknown

Other conditions.....Unknown

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....H. S. Feller MD M. D. or other

Address.....Hancock Md Date signed.....5/4/46

RECEIVED
MAY 8 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Co Hosp.How long in hospital or institution? 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 320 Elizabeth St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Long

3. (b) Social Security Number

Phom4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Premature infant

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, year) May 10, 1946

8. AGE: Years Months Days If less than one day

hrs. 30 min.9. Birthplace Hagerstown
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Chas. L. Long13. Birthplace Maryland14. Maiden name Pearl M. Jones15. Birthplace Maryland16. Informant Chas. L. LongAddress 320 Elizabeth St17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof May 10, 1946
(month) (day) (year)Cemetery or crematory Premises 320 Elizabeth StLocation Hagerstown, Md18. Funeral director Chas. L. Long (father)Address Hagerstown, Md19. May 10, 1946 Chas. L. Long
(Date rec'd by registrar) (Signature)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 May 1946 to 10 May 1946and that I last saw him alive on 10 May 1946Immediate cause of death Prematurely at3 mo. 30 min.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. J. Layman, M.D.

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington
 City or town: Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
126 West Franklin Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington
 City or town: Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 126 West Franklin Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Peter McNeal

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 4, 1869

8. AGE:

Years

Months

Days

If less than one day

77

2

2

hrs.

min.

9. Birthplace

Upsher Co. W.Va.

(Town, county, and state)

10. Usual occupation

Retired Restaurateur

11. Industry or business

FATHER
MOTHER

12. Name

William McNeal

13. Birthplace

Ireland

14. Maiden name

Mary Foy

15. Birthplace

County Mayo, Ireland

16. Informant

Miss Margaret McNeal

Address

Hagerstown, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof: 5-8-1946

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19.

May 7, 1946

Charles H. Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6, 1946

at

3:30

4

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3/46

19

to

19

and that I last saw him alive on May 4/46

Immediate cause of death

Vascular Hypertension
 auricular fibrillation
 coronary heart disease
 chr. myocarditis

DURATION

12yrs

2 yrs

1yr

3yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

no

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. Robert Wells, M.D.

M. D.

Address

Hagerstown, Md.

Date signed

5/6/46

RECEIVED

MAY 9 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05206

303

1. PLACE OF DEATH:

County WashingtonCity or town Clear Spring
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Clear Spring md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Edward H Miller

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Lethan Miller6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.)

Feb 1-1863

8. AGE:

Years 83Months 3Days 14

If less than one day

hrs.

min.

9. Birthplace

Baltimore md

(Town, county, and state)

10. Usual occupation

Retired Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Charles G Miller

13. Birthplace

Germany

14. Maiden name

Anna Gock

15. Birthplace

Germany

16. Informant

Mrs Lethan Miller

Address

Clear Spring md

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 17-1946

(month) (day) (year)

Cemetery or crematory

St. Pauls Cemetery

Location

Near Clear Spring

18. Funeral director

Snyder Rowland

Address

Clear Spring md.

19.

May 17

19.

1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 19 46 at 9:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 15 19 46 to May 15 19 46
and that I last saw him alive on May 14 19 46

Immediate cause of death

Chronic Myocardial Sclerosis

DURATION

2 yrs.

Due to

Due to

Other conditions

Arterio Sclerosis10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David P. Brewer M.D.

M. D. or other

Address

Clear Spring MdDate signed 5/16/46

RECEIVED
MAY 20 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-2)

CERTIFICATE OF DEATH

05207

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Hours
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 8 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Clearspring (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Garrett Emmert Mills

3. (b) Social Security Number
216-22-7651

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) May, 19, 1928 6. (c) If alive, give age _____ years

8. AGE: Years 17 Months 4 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Washington Co. Md.
(Town, county, and state)

10. Usual occupation Labor

11. Industry or business _____

12. Name Amos Mills

13. Birthplace Washington Co. Md.

14. Maiden name Lea Mills

15. Birthplace Washington Co. Md.

16. Informant Amos Mills

Address Clearspring, Md. Rural

17. Burial Date thereof May 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Cemetery

Location Near Clearspring, Md.

18. Funeral director Snyder- Rowland.

Address Clearspring Md.

19. May 15 19 46 Phas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May. 12, 1946 19 _____ at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw h. _____ alive on _____ 19 _____

Immediate cause of death _____

Fatured skull
Shock

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations. None

Date of op. _____

Autopsy results. None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/11/46

Where did injury occur? 2 mile east Clearspring Wash. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Road #40

Means of Injury Auto accident Injured at work? No

Robert Wells DEPUTY MEDICAL EXAM.,
WASH. CO., MD.

23. SIGNATURE _____ M. D. _____

Address Hagerstown, Md. Date signed 5/13/46

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 18 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Tilghmanton Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 54 yrsHospital, institution, or street address where death occurred:
Tilghmanton Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Tilghmanton Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Tilghmanton Md.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Ada Florence Moats

3. (b) Social Security Number

213-24-7653

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
-------------------------	----------------------------------	--

6. (b) Name of husband or wife Paul V. Moats
deceased7. Birth date of deceased (mo., day, yr.) June 24 1891

8. AGE: Years <u>54</u>	Months <u>10</u>	Days <u>12</u>	If less than one dayhrs.min.
----------------------------	---------------------	-------------------	--

9. Birthplace Fairplay Md
(Town, county, and state)10. Usual occupation Chambermaid11. Industry or business Hotel12. Name Samuel L. Line13. Birthplace Fairplay Md14. Maiden name Alice A Line15. Birthplace Fairplay Md16. Informant Ralph L. MoatsAddress Tilghmanton Md.17. Burial Date thereof May 9 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Manor CemeteryLocation Near Tilghamnton18. Funeral director Edith V LeafAddress #7 Church St. Williamsport, Md.19. May 9 19 46 Mrs E L McElroy
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19 46, at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to May 6 19 46and that I last saw him alive on May 6 19 46

Immediate cause of death

Carcinoma of Breast

DURATION

10 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Bank

M. D. or other

Address Williamsport Md Date signed 5/7/46

RECEIVED

MAY 13 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

05209

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Years

Hospital, institution, or street address where death occurred:
334 Summit Ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 334 Summit Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Della Estelle Moulden

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Harry S.

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) September 19 1897

8. AGE: Years 48 Months 7 Days 16 less than one day hrs. min.

9. Birthplace Bunker Hill Berkeley Co. W. Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Hamilton Morgan

13. Birthplace Burnt Factory Va.

14. Maiden name Matilda Jenkins

15. Birthplace Winchester Va.

16. Informant Harry S. Moulden

Address Hagerstown Md.

17. Burial Date thereof 5/7/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Hebron Cemetery

Location Winchester Va.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. May 6 19 46 Blanch Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1946 19 46 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 17 19 46 to May 5 19 46
 and that I last saw him/her alive on May 5 19 46

Immediate cause of death Apoplexy

Due to Hyperemia

Due to 2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D.

Address Hagerstown, Md. Date signed 5-6-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Dr. Pooler

05210

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington

City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 20 Years

Hospital, institution, or street address where death occurred:
43 North Ave

How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 43 North Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war..... NO

3. (a) FULL NAME

Harvey Murray Musselman

3. (b) Social Security Number

214-09-1401

4. Sex..... Male

5. Color or race..... White

6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Mary V.

7. Birth date of deceased (mo., day, yr.)..... Nov. 4, 1877

8. (c) If alive, give age..... years

8. AGE: Years..... 68 Months..... 6 Days..... 4 If less than one day..... hrs. min.

9. Birthplace..... Fairfield Adams Coty. Penna.
(Town, county, and state)

10. Usual occupation..... Salesman11. Industry or business..... Schindler And Roher Co.12. Name..... Russel Musselman13. Birthplace..... Fairfield, Penna.14. Maiden name..... Virginia Marshall15. Birthplace..... Fairfield, Penna.16. Informant..... Mrs. Mary MusselmanAddress..... Hagerstown, Maryland

17. Burial..... Burial Date thereof..... May 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill CemeteryLocation..... Hagerstown, Maryland18. Funeral director..... Andrew K. CoffmanAddress..... Hagerstown, Maryland

19. May 13 19 46 Blair Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 11, 19 46 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 1945 to May 11 19 46
and that I last saw him alive on May 4 19 46

Immediate cause of death.....

Coronary Occlusion DURATION 10 min
Due to..... 2nd Attack

Coronary Occlusion 11 mo
Due to..... 1st Attack

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Ernest H. Pooler MDAddress..... Hagerstown Md. Date signed..... 5/11/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05211

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:
224 South Potomac Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 224 South Potomac Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Albert R. Myers

3. (b) Social Security Number

174-01-3970

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Ella Marken
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 7, 1883
 8. AGE: Years 62 Months 5 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Akron, Ohio
 (Town, county, and state)
 10. Usual occupation Moulder
 11. Industry or business Kauffman Foundry
 12. Name George Myers
 13. Birthplace Leitersburg, Maryland
 14. Maiden name Ella Marken
 15. Birthplace Wolfsville, Maryland

16. Informant Robert Myers
 Address Hagerstown, Maryland
 17. Burial Date thereof 6-3-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Harbaugh Cemetery
 Location Rouzer ville, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland
 19. June 3, 1946 Charles H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 - 1946 at 6:20 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 15 - 1946 to May 31 - 1946
 and that I last saw him alive on May 31 - 1946
 Immediate cause of death _____

DURATION
Cardiac Failure
Due to Disturbance from Angina 2 days
Due to Acute Bronchitis
 Other conditions Acute Neuritis of Arm & neck
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Charles H. Bowers M. D. or other _____
 Address Hagerstown, Md. Date signed 6/1/46

11907

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D.C.

RECEIVED
JUN 5 1946
BUREAU V.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
City or town near Boonsboro Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town near Boonsboro Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAME

Leon Ellwood Nethy

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

6. (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr.) September 9, 1942

8. AGE: Years 3 Months 7 Days 24 If less than one day hrs. min.

9. Birthplace near Boonsboro Wash. Co. Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business at home

12. Name William E. Nethy

13. Birthplace near Boonsboro Wash. Co. Md.

14. Maiden name Juanita Thomas

15. Birthplace Woodsville Wash. Co. Md.

16. Informant William Nethy

Address Boonsboro Md. R. 2

17. Burial Date thereof May 7, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Best & Sons

Address Boonsboro Md.

19. May 7 19 46 John H. Best
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 46 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on May 3 19 46 to May 3 19 46

and that I last saw him alive on May 3 19 46

Immediate cause of death Lobar pneumonia

DURATION

4 days

Due to Paraplegia

Other conditions life

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide none Date of none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury none Injured at work? none

23. SIGNATURE Walter H. Shalaby

M. D. or other none

Address May 6 Shalaby Date signed May 6

Address May 6 Shalaby Date signed May 6

Address May 6 Shalaby Date signed May 6

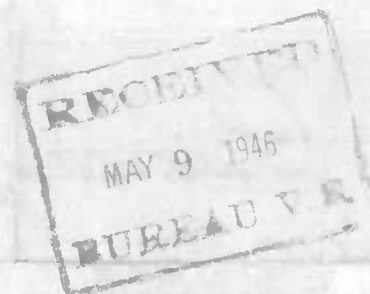
Address May 6 Shalaby Date signed May 6

Address May 6 Shalaby Date signed May 6

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(5213)

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

24 years

Hospital, institution, or street address where death occurred:

115 E. Franklin St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.

115 E. Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Alverta C. Poe

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

EDward Poe

6.(c) If alive, give age

43 years

7. Birth date of deceased (mo., day, yr.)

May 24, 1905

8. AGE:

Years

Months

Days

If less than one day

40

11

7

hrs.

min.

9. Birthplace Rouzersville Franklin Pa.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

Own Home

FATHER

12. Name

Jacob D. Seese

13. Birthplace

Rouzersville Pa.

MOTHER

14. Maiden name

Anna Witmer

15. Birthplace

Rouzersville Pa.

16. Informant

Mr. Edward Poe

Address

Hagerstown Md.

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Harbaugh's Cemetery

Rouzersville Pa.

Location

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

May 3, 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1946, at 2 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6, 1946 to May 1, 1946
and that I last saw her alive on April 30, 1946

Immediate cause of death

DURATION

Metastatic carcinoma
carcinoma primary
of right breast.

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

carcinoma of right
breast. Radical amp. Date of op. May 6, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Ra Bee
Hagerstown Md.

Date signed

5-1-46

RECEIVED

MAY 5 1946

BUREAU VS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1521502

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:

724 George St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 723 George St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mildred Betts Poffenberger

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Divorced

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1905
8.(c) If alive, give age _____ years

8. AGE: Years 40 Months 5 Days 17 It less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Wash. Co. Maryland.
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name David J. Betts

13. Birthplace Fiddlersburg, Maryland.

14. Maiden name Minnie I. Mundy

15. Birthplace Hagerstown, Maryland.

16. Informant David J. Betts.

Address 724 George St. Hagerstown, Md.

17. Burial Rest Haven Cemetery
(Burial, cremation, or removal. Which?) Date thereof June 2, 1946
(month) (day) (year)

Cemetery or crematory Hagerstown, Maryland.

Location Fred W. Kraiss

18. Funeral director Hagerstown, Md.

Address Hagerstown, Md.

19. June 1 19 46
(Date rec'd by registrar)

Registrar Phoebe Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 46 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 12 19 45 to May 30 19 46
and that I last saw him alive on May 25 19 46

Immediate cause of death

Pulmonary Tuberculosis 4 yrs

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry Hovenster M. D. or other

Address Hagerstown, Md. Date signed 5/31/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

27

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County... Washington
 City or town... Rural Smithsburg #2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... Washington
 City or town... Rural Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Smithsburg #2
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Harry L. Ponton

3. (b) Social Security Number

220-09-9141

4. Sex

m

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Lusie Barrett

7. Birth date of

deceased (mo., day, yr.)

May 11 1884

6. (c) If alive, give age

41 years

8. AGE:

Years

Months

Days

It less than one day

4300hrs.min.

9. Birthplace

London Co. Va.

(Town, county, and state)

10. Usual occupation

Businessman

11. Industry or business

Hagerstown Rubber Co.

FATHER

12. Name

James Ponton

13. Birthplace

H. Va.

MOTHER

14. Maiden name

Emma Florence Mays

15. Birthplace

London Co., Va.

16. Informant

Mrs Harry Ponton

Address

Smithsburg #2 Md.

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

5/14/46
(month) (day) (year)

Cemetery or crematory

Rest Haven

Location

Hagerstown Md.

18. Funeral director

Walter J. Huns

Address

27 S. Church St. Waymaville, Va.

19.

May 13 1946
(Date rec'd by registrar)Geo. W. Fagnano
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 11

19.

46 at 6 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 11

19.

46 to May 11

19.

and that I last saw him

May 11

19.

46

Immediate cause of death

Pulmonary Embolism

DURATION

5 hours

Due to

Myocardial Infarction

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. G. K. Oyster

M. D. or other

Address

Smithsburg

Date signed

5/11/46

RECEIVED
MAY 25 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126

CERTIFICATE OF DEATH

Dr. Yeager

Reg. Dist. No. 15217 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Washington County Hospital
Stay in hospital or inst. (yrs., or mos., or days) 6 Days
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 246 North Mulberry St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME

Melvin Washington Reeder

3. (b) Social Security Number

214-09-9993

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

B (b) Name of husband or wife Myree

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) September 9 1902

8. AGE: Years 43 Months 7 Days 29 hrs. _____ min. _____

9. Birthplace Boonsboro Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Sheet Metal Worker

11. Industry or business Pangborn Corp.

FATHER 12. Name Samuel Reeder

13. Birthplace Boonsboro Md.

MOTHER 14. Maiden name Della Easterday

15. Birthplace Boonsboro Md.

16. Informant Mrs. Myree Reeder

Address Hagerstown Md.

17. Burial Date thereof 5/10/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. May 11 46 Registrar Chas. H. Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1946 E.O.T. 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1946 to May 8, 1946
and that I last saw him alive on May 7, 1946

Immediate cause of death Cholelithiasis -
gallstones obstructing common
Due to gallstones 9 days
Due to gallstones 9 days
Other conditions Chronic Pelvic Infection 1 yr +

(Include pregnancy within 3 months of death)

Major findings: No operation.

Of operations _____

Of autopsy Yes - see above.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE W. Howard Yeager M. D. or other _____
Address Hagerstown Md. Date signed May 8, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

RECEIVED

MAY 14 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BPE)

CERTIFICATE OF DEATH

05218

Reg. Diat. No.

1. PLACE OF DEATH:

County WashingtonCity or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

Hancock R F D #1How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 40 - 4 mi. West of Hancock
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (a) FULL NAME

Lewis Albert Richards

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mina Hoffman Richards6. (c) If alive, give age 73 years

7. Birth date of

deceased (mo., day, yr.)

October 29, 1869

8. AGE:

Years

Months

Days

If less than one day

76611— hrs.— min.9. Birthplace Amaranth, Fulton Co., Penna.
(Town, county, and state)10. Usual occupation Lumberman & Farmer11. Industry or business —

FATHER

12. Name David Richards13. Birthplace Fulton Co., Penna.

MOTHER

14. Maiden name Malinda Lanehart15. Birthplace Fulton Co., Penna.16. Informant James D. RichardsAddress 20 Redwood St., Chambersburg, Penna.17. Burial Date thereof May 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Church of the BrethrenLocation Amaranth, Penna.18. Funeral director Charles R. BastAddress Hancock, Maryland19. 5/11/46 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 46 at — M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 19 46 to May 10 19 46
and that I last saw him in alive on May 8 19 46

Immediate cause of death

Myocarditis

DURATION

Due to

Chronic
nephritis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. M. J. Huffer MD

M. D. or other

Address Hancock Md Date signed 5/11/46

RECEIVED
MAY 15 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

26

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

15219308

1. PLACE OF DEATH:
 County Main St. Wash.
 City or town Clear Spring Md.
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution: Main St.
 Stay in hospital or inst. (yrs., or mos., or days) _____
 Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For new-born infants give residence of mother)
 State Penna. County Franklin
 City or town H. London, Pa. Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. _____
 (If rural give LOCATION)
 2(a) IF VETERAN, NAME WAR WW2 ☒

3. (a) FULL NAME Cledus W. Robinson 3(b) Social Security Number none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife _____
 6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1922

8. AGE: Years 24 Months 4 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Franklin Co., Penna.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

FATHER 12. Name Norman T. Robinson

13. Birthplace Franklin Co. Pa.

MOTHER 14. Maiden name Mary Schi

15. Birthplace Franklin Co. Pa.

16. Informant Norman T. Robinson

Address H. London, Pa.

17. Burial Date thereof May 10, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Thomas Ceme.

Location St. Thomas, Pa.

18. Funeral director F.M. Lininger

Address Mercersburg, Pa.

19. May 7 19 46 Joseph W. Mumay
 (Date registered by Registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1946 19 46 at 11:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7, 1946 to May 7, 1946
 and that I last saw him alive on May 7, 1946

Immediate cause of death Acute Heart Failure DURATION Sudden

Due to Anesthetic for
Lonsollectomy

Due to Patient became suddenly
cyanotic and died
before operation was begun

Other conditions (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David R. Greener MD

Address Clear Spring Md. M. D. or other _____

Date signed 5/7/46

RECEIVED
MAY 9 1946
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 120-2

CERTIFICATE OF DEATH

05220

Reg. Dist. No. 3021

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 yearsHospital, institution, or street address where death occurred:
422 George St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 422 George St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hynitha Roland4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M6.(b) Name of husband or wife James Roland6.(c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) Nov. 24, 18798. AGE: Years 66 Months 5 Days 9 If less than one day hrs. min.9. Birthplace Franklin Co., Penna.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Robinson13. Birthplace Penna.MOTHER 14. Maiden name Ellen Pine15. Birthplace Fulton Co., Penna.16. Informant James RolandAddress 422 George St., Hagerstown, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1946
(month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director L. F. ReeherAddress Funkstown, Md.19. May 4, 1946 Registrar
(Date rec'd by registrar)

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1946 at 4:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 1946 to May 3, 1946and that I last saw him/her alive on May 3, 1946Immediate cause of death Coronary Arteriosclerosis

DURATION

5 days

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

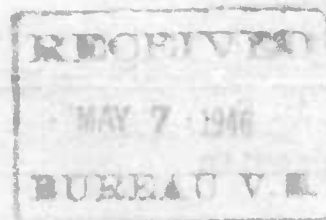
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Beachy, M.D.Address Hagerstown, Md. Date signed May 3, 1946

STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 123

CERTIFICATE OF DEATH

05221

Reg. Dist. No. 302

1. PLACE OF DEATH:-

County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Co Hospital
17 days

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn County Franklin

City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 134 E. Franklin St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARETTA LAZELL GASTEP ROTH

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Yosh S. Roth

deceased B. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 13 1880

8. AGE: Years Months Days it less than one day
65 6 14 _____ hrs. _____ min.

9. Birthplace Franklin Co. Pa
 (Town, county, and state)

10. Usual occupation House wife & House mother

11. Industry or business

FATHER 12. Name Daniel Foster

13. Birthplace Penn

MOTHER 14. Maiden name Not known

15. Birthplace Not known

16. Informant Mrs Russel Locke

Address 118 E. S. Burley St Mt Union Pa

17. Burial Date thereof May 31 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baptist Cemetery

Location Cassell Huntington Co. Pa

18. Funeral director Mrs David Martin

Address Frederick Pa

19. May 28 46 Christ Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1946 19 _____ 6:13 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1946 19 _____ to May 27, 1946

and that I last saw h. er. alive on May 27, 1946 19 _____

Immediate cause of death

Bronchial pneumonia

DURATION

5 days

Due to

Due to

Other conditions Rectal abscess with septicemia 27 days

Chronic hypertensive nephritisIndef.

(Include pregnancy within 3 months of death)

Major findings of operations Extensive rectal abscess

Date of op. May 11, 1946Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE B. B. Bowers M. D. or other

Address 148 W. Washington St. Date signed 5/28/46

RECEIVED

MAY 30 1946

BUREAU U.S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County ~~Washington~~ **Washington**
 City or town **Hagerstown, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

219 West Side Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Washington**
 City or town **Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)

Street No. **219 West Side Avenue**

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mary C. Shilling

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

James H. Shilling

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 14, 1867

8. AGE:

Years

78

Months

9

Days

1

If less than one day

hrs.

min.

9. Birthplace

Funkstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

Robert Albert

13. Birthplace

Washington Co. Md

MOTHER

14. Maiden name

Rebecca Gray

15. Birthplace

Washington Co. Md

18. Informant

Mrs. Angle Wolfinger

Address

Hagerstown, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof **5-18-46**

(month) (day) (year)

Cemetery or crematory

Rose Hill

Location

Hagerstown Md

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19. (Date rec'd by registrar)

May 18 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 15 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 10 1945 to May 15 1946

and that I last saw him alive on

May 15 1946

Immediate cause of death

Coronary occlusion

DURATION

5/15/46

Due to

**Arteriosclerosis
Hypertension**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. H. Porterfield M.D.

M. D. or other

Address

136 W WashingtonDate signed **5/17/46**

RECEIVED

MAY 21 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age and birthdate is shown on
is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the addition of
age and birthdate is shown
on
G107 9/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462 ✓

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hyattsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital Hyattsville

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County Franklin

City or town Greencastle, Pa.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Harman Shines

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

June 6, 1881

8. (c) If alive, give age _____ years

8. AGE:

Years 64 Months 10 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Fulton Co. Pa.

(Town, county, and state)

10. Usual occupation Retired farmer and

11. Industry or business live stock dealer

12. Name Jacharia Shines

13. Birthplace Fulton Co. Pa.

14. Maiden name Eliza Snyder

15. Birthplace Fulton Co. Pa.

16. Informant Mrs. Harman Shines

Address

Greencastle Pa.

17. Burial
(Burial, cremation, or removal, Which?)

Date thereof May 6 - 46
(month) (day) (year)

Cemetery or crematory Fairview Cem.

Location Franklin Co. Mercersburg, Pa.

18. Funeral director H. W. Krieger

Address

Mercersburg, Penna.

19. May 3, 1946
(Date rec'd by registrar)

Health Officer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1946, at _____ M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/1/46 1946, to 5/3/46

and that I last saw him live alive on 5/3/46 1946

Immediate cause of death

Carcinoma of stomach

DURATION

Unknown

Due to _____

Due to _____

Other conditions Pulmonary tuberculosis

Myocardial infarction

(Include pregnancy within 3 months of death)

4 yrs (?)

Unknown

Major findings of operations _____

Date of op. _____

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____

M. D. or other

Address 154 W. Washington St. Date signed 5/3/46

Hyattsville, Md.

RECEIVED
MAY 5 1946
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

05224

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 years
 Hospital, institution, or street address where death occurred:
423 Salem Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 423 Salem Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

George F. Smith

3.(b) Social Security Number

213-18-9335

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary E. Smith
 7. Birth date of deceased (mo., day, yr.) June 27, 1875 B.(c) If alive, give age _____ years
 8. AGE: Years 70 Months 10 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Middletown, Virginia
 (Town, county, and state)
 10. Usual occupation Plasterer
 11. Industry or business

FATHER 12. Name John W. Smith
 13. Birthplace Virginia
 MOTHER 14. Maiden name Jacqueline Hinkins
 15. Birthplace Virginia

16. Informant Mrs. Mary E. Smith
 Address 423 Salem Ave.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 4, 1946
 (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. May 4, 1946 Charles H. Bowers
 (Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1946 10:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 15 1946 to May 1 1946
 and that I last saw him alive on Apr 30 1946

Immediate cause of death Chr. Interstitial Nephritis
Chr. Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D. M. D. or otherAddress Hagerstown, Md. Date signed 5-1-46

RECEIVED

MAY 7 1946

BUREAU V.R.

ARTESIAN LEDGER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

05225

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**
 County **Hagerstown**
 City or town **Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **6 Years**
 Hospital, institution, or street address where death occurred:
316 W. Wilson Blvd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Maryland** County **Washington**
 City or town **Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **316 West Wilson Boulevard**
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
James Clinton Smith

3. (b) Social Security Number
None

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Single**
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) **Sept. 20-1890**
 8. AGE: Years **55** Months **8** Days **8** If less than one day hrs. min.

9. Birthplace **Hagerstown, Washington Co. Md**
Laborer (City, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name **Joseph Smith**
 13. Birthplace **England**

MOTHER 14. Maiden name **Margaret Walls**
 15. Birthplace **Heighton, N. J.**

16. Informant **Mrs William B. Sand**
 Address **Hagerstown Md**

Burial Date thereof **May 30- 1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Rest Haven**
Hagerstown, Md
 Location

18. Funeral director **C. M. Suter & Sons**
Hagerstown, Md
 Address

19. **May 29 1946** **Chas H. Bowers**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 27 1946** at **11 P.** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan 4 1946** to **May 27 1946**
 and that I last saw him alive on **May 27 1946**

Immediate cause of death **Cerebral Hemorrhage** DURATION **3 days**

Due to **Cerebral Hemorrhage** 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **E. G. H. O. H. S.** M. D. or other

Address **Smithsburg** Date signed **5/25/46**

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ED

JUN 1 1946

BUREAU V.S.

REC

JUN 1 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
815 Frederick Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Minnie May Smith

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Albert Smith

7. Birth date of deceased (mo., day, yr.) July 17, 1871 6. (c) If alive, give age _____ years

8. AGE: Years 74 Months 9 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Boonsboro Washington Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name David Martz
 13. Birthplace Wash. Co. Md.

MOTHER 14. Maiden name Mahalia Reeder
 15. Birthplace Wash. Co. Md.

16. Informant Mr. Walter Cleland
 Address Hagerstown Md.

17. Burial Date thereof May 15, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Boonsboro Cemetery
 Location Boonsboro Md.

18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. May 14 19 46 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 19 46 at 8:35a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/8 19 46 to 5/13 19 46
 and that I last saw him alive on 5/13 19 46

Immediate cause of death Carcinoma uterine.
Chronic Endocarditis
hypertension
 Due to _____ DURATION 21

Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas. H. Bowers M. D. or other _____

Address Hagerstown Date signed 5/13-1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 16 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Dr. Campbell

05227

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

Hill Crest Nursing HomeHow long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 228 Summit Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (a) FULL NAME

Mrs. Emily Snyder

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Whits

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Elmer

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

February 7 1864

8. AGE:

Years

Months

Days

If less than one day

82227

hrs.

min.

9. Birthplace

York York Co. Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

MOTHER FATHER

12. Name

George Metcalf

13. Birthplace

Baltimore Md.

14. Maiden name

Glovenia Hamilton

15. Birthplace

Baltimore Md.

16. Informant

Mrs. Eva Rouzer

Address

Hagerstown Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

5/7/46

(month) (day) (year)

Cemetery or crematory

Green mount Cemetery

Location

Baltimore Md.

18. Funeral director

Andrew K: Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

19 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1946 19_____, at 3.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May1945to May 41946

and that I last saw him alive on _____ 19____

Immediate cause of death

Cardio-vascular disease

DURATION

6 M.

Due to

Atherosclerosis

Due to

Other conditions

Pharyngeal BroucheMass lower abdominal quadrant - nature not determined
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Dr. CampbellM. D. only

Address

Hagerstown MdDate signed May 4/46

RECEIVED
MAY 7 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05228

87

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 Years

Hospital, institution, or street address where death occurred:

510 Ridge Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland Washington

County... Hagerstown

City or town... (If outside city or town limits, write RURAL and give nearest town)

510 Ridge Ave.

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret G. Stonesifer

3. (b) Social Security Number

None

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed	
6.(b) Name of husband or wife Elmer E. Stonesifer			
6.(c) If alive, give age... years			
7. Birth date of deceased (mo., day, yr.) June 28, 1864			
8. AGE: Years 81	Months 10	Days 27	If less than one day hrs. min.

9. Birthplace... Charlestown, Jefferson co. W. Va.
(Town, county, and state)

10. Usual occupation... House Wife

11. Industry or business

12. Name... John J. Avis

13. Birthplace... Charlestown, Jefferson Co. W. Va.

14. Maiden name... Mary O'Neil

15. Birthplace... Fredrick, Maryland.

16. Informant... Mrs. Trumpower

Address... 510 Ridge Ave. Hagerstown, Md.

17. Burial Date thereof... May 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Edge Hill Cemetery

Location... Charlestown, W. Va.

18. Funeral director... Fred W. Kraiss

Address... Hagerstown, Maryland.

19. May 28 1946 by Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 25, 1946 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/25/46 19 5/25/46 19

and that I last saw him alive on 5/25/46 19

Immediate cause of death... Coronary Occlusion

DURATION

Immediate

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. F. G... M.D. or other

Address... Williamsport, Md. Date signed 5/27/46

RECEIVED

MAY 30 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

05229

73

Reg. Dist. No. 302

1. PLACE OF DEATH:
 County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
Life
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
552 Church Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Maryland Washington
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
552 Church Street
 Street No. 552 Church Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME
Roy Albert Stouffer

3.(b) Social Security Number
214-09-3364

4. Sex Male
 5. Color or race White
 6.(a) Single, married, widowed, or divorced
 6.(b) Name of husband or wife
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 24, 1984
 8. AGE: 62 Years 1 Months 23 Days
 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Washington Co. Md.
 (Town, county, and state)
 10. Usual occupation Driver

11. Industry or business

12. Name John M. Stouffer
 13. Birthplace Akron Ohio

14. Maiden name Isabelle Mace
 15. Birthplace Hagerstown, Maryland

16. Informant Charles W. Anderson
 Address 552 W. Church Street. Hagertown

17. Burial Burial Date thereof May 17, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown, Maryland.
 Location F. W. Kraiss

18. Funeral director F. W. Kraiss
 Address Hagerstown, Maryland.

19. May 17 19 46 Blackbourn
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1946 19 46 7:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 46 to May 10 19 46
 and that I last saw him alive on 4/6 19 46

Immediate cause of death Carcinoma of esophagus DURATION 8 mos.

Due to ✓

Due to ✓

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of esophagus
 Date of op 3/29/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Anderson M. D. or other

Address 1700 West St Date signed 3/1/48

RECEIVED

MAY 20 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

05230

84

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Stagerstown
 City or town Stagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 years
 Hospital, institution, or street address where death occurred:
22 Ruby Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Stagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 22 Ruby Avenue
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

George Stribling

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 8, 1876 8. (c) If alive, give age years

8. AGE: Years 70 Months 2 Days 15 If less than one day hrs. min.

9. Birthplace Shepherdstown, W. Va.
 (Town, county, and state)
Laborer

10. Usual occupation

11. Industry or business

12. Name Jack Stribling13. Birthplace Shepherdstown, W. Va.14. Maiden name Mary Stevens15. Birthplace Shepherdstown, W. Va.16. Informant Mrs. Augusta KeyserAddress 220 N. Jonathan Street17. Burial Date thereof 5/27/46
 (Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Stagerstown, Md.18. Funeral director William H. DonnerAddress 291 Frederick St.

19. May 27 19 46 Chas. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION E.D.S.T.20. DATE OF DEATH May 23 19 46 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death..... DURATION

Chr. Myocarditis 5 yrsDue to acuteVentricular fibrillation

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

no Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Robert Wells DEPUTY MEDICAL EXAM.,Signature, Md. M. D. WASH. CO., MD.Date signed 5/25/46

RECEIVED

MAY 29 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH

County Washington
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crash. Co. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Bethesda 'Rural'
 (If outside city or town limits, write RURAL and give nearest town)Street No. Bethesda Md. R. 2
 (If rural, give LOCATION)2(a) If veteran, name war none

3. (a) FULL NAME

Infant Thomas

3. (b) Social Security Number

none4. Sex ♂ 5. Color or race White 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years May 30, 1946 Months 0 Days 0 If less than one day9. Birthplace Bethesda Md.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Norman Thomas13. Birthplace Sharpsburg Wash. Co. Md.14. Maiden name Ethel J. Marshall15. Birthplace Kedzieville Wash. Co. Md.16. Informant Mr. Norman ThomasAddress Bethesda Md. R. 217. Burial Date thereof June 1 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain View CemeteryLocation Sharpsburg Md.18. Funeral director Wm. J. Bart & SonAddress Bethesda Md.19. May 31 46 Registrar Robert Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1946 19... at 9 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at birth 19... to 19...and that I last saw him alive on 19...Immediate cause of death Prematurity - 4 1/2 Mos.DURATION
4 hoursDue to unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Walter K. Shealy M.D.

M.D. or other

Address Sharpsburg Md. Date signed 5/31/46

RECEIVED

JUN 2 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1105 Potomac Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Philip Standish Walsh

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
<u>Male</u>	<u>White</u>	<u>Married</u>	
6. (b) Name of husband or wife. <u>Mary C. Walsh</u>			
6. (c) If alive, give age. <u>52</u> years			
7. Birth date of deceased (mo., day, yr.) <u>December 19, 1892</u>			
8. AGE:	Years	Months	Days
	<u>53</u>	<u>4</u>	<u>14</u>
If less than one dayhrs.min.			

9. Birthplace... Fall River, Mass.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business War Department12. Name... Philip Walsh13. Birthplace... Fall River, Mass.14. Maiden name... Henrietta Danish15. Birthplace... Fall River, Mass.16. Informant... Mrs. Philip WalshAddress... Hagerstown, Maryland17. Removal Date thereof... 5-3-46

(Burial, cremation, or removal. Which?) (month, day, year)

Cemetery or crematory... St. Patricks CemeteryLocation... Fall River, Mass.18. Funeral director... C. M. Suter & SonsAddress... Hagerstown, Maryland19. May 3 19 46 Chas H Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 3 19 46 at 9:42 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28 19 46 to May 3 19 46and that I last saw him alive on May 12 19 46

Immediate cause of death.....

Coronary Occlusionof anterior typeDue to... arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Robert V. L. Campbell M.D.Address... 145 W. Washington St. Date signed... 5/3/46

M. D. or other

RECEIVED
MAY 5 1946
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 440

CERTIFICATE OF DEATH

Reg. Dist. No. 5233302

1. PLACE OF DEATH:

County Washington
City or town 3 Dunkstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred: Main St.
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Dunkstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME

Jacob Martin Warrenfeltz

3. (b) Social Security Number

214-09-2950

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Ethel Mc Coy Warrenfeltz
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January - 22 - 1892

8. AGE: Years 54 Months 3 Days 18 It less than one day hrs. mins.

9. Birthplace Dunkstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Mill Superintendent

11. Industry or business Hagerstown Lumber Co.

12. Name Neudor J. Warrenfeltz

13. Birthplace Dunk. Co. Md.

14. Maiden name Stella Stockslager

15. Birthplace near Hagerstown Wash. Co. Md.

16. Informant Mrs. Ethel Mc Coy Warrenfeltz
Address Dunkstown Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 13, 1946
(month) (day) (year)

Cemetery or crematory Dunkstown Cemetery

Location Dunkstown Md

18. Funeral director Wm. J. Best & Sons

Address Boonsboro Md

19. May 12, 46 Chas. Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 46, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1946 to May 10, 1946

and that I last saw him alive on May 10, 1946

Immediate cause of death Thrombosis of

Left. femoral artery

Due to Coronary Thrombosis

Pulmonary Infarct

Due to Cerebral Embolism

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Adrian Zoverster M.D.
M. D. or other

Address Dunkstown, Md. Date signed 5/11/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1946
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Diat. No. 303

1. PLACE OF DEATH:

County... Washington
Hancock, Rural

City or town... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Hancock, Rural
(If outside city or town limits, write RURAL and give nearest town)Street No...
(If rural, give LOCATION)

2.(a) If veteran, name war...

3.(a) FULL NAME

Christine Adeline Weller

3.(b) Social Security Number

NONE

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife Hiram Weller

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) October 7 1855

8. AGE: Years Months Days If less than one day
90 7 16 ...hrs. ...min.9. Birthplace... Fulton Co. Pa.
(Town, county, and state)

10. Usual occupation... Home Work

11. Industry or business

12. Name... Joseph Fritz

13. Birthplace... Franklin Co. Pa.

14. Maiden name... Catherin Secrist

15. Birthplace... Franklin Co, Pa.

16. Informant... Mrs. John Helser

Address... Hancock, Rural

17. Burial Date thereof... May 26 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... STPauls Cemetery

Location... Near Clearspring, On U.S. 40

18. Funeral director... Snyder, Rowland

Address... Hancock, Md

19. May 25 19 46 Joseph W. Murray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 23 19 46, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 19 45 to May 22 19 46
and that I last saw her alive on May 22 19 46

Immediate cause of death... DURATION

Cerebral hemorrhage 20 yrs

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... M. D. or other

Address... Hancock, Md Date signed... 5/24/46

RECEIVED

MAY 28 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

15235

Reg. Dist. No. 303

1. PLACE OF DEATH: **Washington**
 County **Hagerstown**
 City or town **Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **2 weeks**
 Hospital, institution, or street address where death occurred:
912 Hamilton Blvd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Maryland** County **Washington**
 City or town **Funkstown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Funkstown, Maryland**
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME **Mollie Shilling Welty**

3. (b) Social Security Number
None

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Widow**
Alfred Welty
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) **May 27 - 1869**
 8. AGE: Years **76** Months **11** Days **16** If less than one day _____ hrs. _____ min.

9. Birthplace **Funkstown Washington Co. Md**
 (Town, county, and state)
Housework

10. Usual occupation
 11. Industry or business

FATHER **Frederick E. Shilling**
 12. Name **Funkstown, Maryland**
 13. Birthplace **Margaret Kendell**
 14. Maiden name **Funkstown, Maryland**
 15. Birthplace

16. Informant **Frederick E. Shilling**
Hagerstown, Maryland
 Address

17. **Burial** Date thereof **5-16-46**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
Funkstown Cemetery
 Cemetery or crematory **Funkstown, Maryland**
 Location **C. M. Suter & Sons**

18. Funeral director **Hagerstown, Maryland**
 Address

19. **May 16** 19 **46** **Clas H. Bowser**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 13, 1946** at **9:00 P. M.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **February 3, 1933** to **May 13, 1946**
 and that I last saw him alive on **May 10, 1946**
 Immediate cause of death

Hypertensive Cardiac
vascular-Renal disease
 DURATION **13 years**
 Due to

Due to
 Other conditions **Arteriosclerosis** **13 years**

(Include pregnancy within 3 months of death)
 Major findings of operations **No operation**
 Date of op.

Autopsy results **No autopsy**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE **Ra Bell**
Hagerstown Md M. D. or other
 Address Date signed **5/14/46**

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MAY 18 1946

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